

EXHIBIT C

**IN THE UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY**

PATIENT CARE ASSOCIATES, LLC a/s/o
PATRICIA M.,

Plaintiff,

vs.

AUTOMATIC DATA PROCESSING, INC.,
ET AL.,

Defendants.

Civil Action No. 12-cv-3718
(DRD/PS)

**CONFIDENTIAL CERTIFICATION OF MICHAEL C. McNAMARA
IN SUPPORT OF DEFENDANT AUTOMATIC DATA PROCESSING, INC.'S MOTION
FOR SUMMARY JUDGMENT**

I, Michael C. McNamara, of full age hereby certify as follows:

1. I am currently employed by Aetna Life Insurance Company (hereinafter "Aetna") as a Litigation Paralegal.
2. The statements below are based upon my personal knowledge and expertise gained through my employment with Aetna. This Certification is offered to certify facts in support of the present Motion for Summary Judgment filed by Defendant Automatic Data Processing, Inc. (hereinafter "ADP").

A. FACTS RELEVANT TO THIS LITIGATION

3. Patricia M. received health benefits via a self-insured employee health benefit plan (hereinafter the "Plan") sponsored by ADP that is administered by Aetna, and governed by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq.

4. The claims at issue in this litigation were for services rendered to Patricia M. as part of an outpatient surgical procedure on or about December 10, 2010 (hereinafter the "Procedure"), at a facility of Plaintiff Patient Care Associates, LLC (hereinafter "PCA").

5. The Plan contains a mandatory, two-level administrative appeals process which must be exhausted prior to initiating any lawsuit. Pursuant to the Plan, all appeals are to be sent to: Aetna, P.O. Box 14586, Lexington, KY 40512-4586.

6. In the ordinary course of business, Aetna maintains a database that contains appeals and supporting appeals documentation filed by or on behalf of Aetna members.

7. Aetna does not have any appeals on file for the services at issue in this litigation, either filed by Patricia M., PCA, or anyone purporting to act on behalf of Patricia M.

B. DOCUMENTS RELEVANT TO ADP'S PRESENT MOTION

8. Attached hereto as Exhibit A is a true and correct copy of the relevant portions of the Summary Plan Description effective as of December 10, 2010, for the Plan sponsored by ADP, bearing bates stamp numbers ADP000113-150.

9. Attached hereto as Confidential Exhibit 1 is a true and correct copy, as produced to ADP by PCA in discovery, of the claim form submitted to Aetna related to the Procedure, bearing bates stamp numbers PCA000001.¹

10. Attached hereto as Confidential Exhibit 2 is a true and correct copy of the Member Claim Summary generated by Aetna for the claims submitted for payment by PCA related to the Procedure, bearing bates stamp numbers ADP000162.

¹ Documents herein designated as "Confidential Exhibits" were designated as Confidential Health Information under the Stipulated Discovery Confidentiality Order governing this action.

11. Attached hereto as Confidential Exhibit 3 is a true and correct copy of the Explanation of Benefits generated by Aetna and issued to Patricia M. for the claims submitted for payment by PCA related to the Procedure, bearing bates stamp numbers ADP000151-153.

12. Attached hereto as Confidential Exhibit 4 is a true and correct copy of the provider Explanation of Benefits generated by Aetna for the claims submitted for payment by PCA, and issued to PCA by Aetna, bearing bates stamp numbers ADP000164.

13. Attached hereto as Confidential Exhibit 5 is a true and correct copy of the Claim Payment Summary generated by Aetna for the claims submitted for payment by PCA, bearing bates stamp numbers ADP000161.

14. Attached hereto as Confidential Exhibit 6 is a true and correct copy of the Member Claim Summary generated by Aetna for the claims submitted for payment by PCA, bearing bates stamp numbers ADP000163.

15. Attached hereto as Confidential Exhibit 7 is a true and correct copy, as produced to ADP by PCA in discovery, of the March 15, 2011 letter PCA addressed to Aetna in El Paso, TX, bearing bates stamp numbers PCA000005-6.

I certify under penalty of perjury that the foregoing is true and correct.

DATED: February 8, 2013

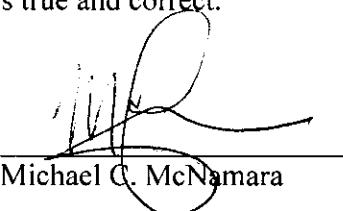

Michael C. McNamara

EXHIBIT A

Medical Benefits

Your Options

ADP offers several Medical coverage options to each eligible associate. These options cover many of the same services; however, contributions, deductibles, co-payments and annual out-of-pocket limits vary. It is important to carefully weigh the differences between each Medical option to make sure your specific needs will be covered. **You will not be permitted to change options because your doctor drops out of the Plan.**

Note: There is no pre-existing condition exclusion under the Medical Plan.

Medical eligibility is determined by your home Zip Code. To determine your plan eligibility:

Log onto www.adpassociate.com
Select the Benefits link from the top of the page
Select 2009 Plan Information
Select Medical/Dental Plans and Rates
Select the Plan year and then enter your home zip code

Refer to the 2009 link under the Benefits section for the HMO/Choice POS II / Choice Plus Benefit Summaries.

Option 1	Aetna Choice POS II or United Healthcare Choice Plus (\$325 in-network deductible)
Option 2	Aetna Choice POS II or United Healthcare Choice Plus (\$1,100 in-network deductible)
	Note: If you are not in the UHC zip code service area, you will not be permitted to elect the UHC plan
Option 3	HMO
Option 4	No Coverage – offers full and part time associates (working at least 20 hours per week) the flexibility of taking no ADP medical coverage.

Eligibility and Enrollment

All regular associates working 20 or more standard hours per week (16 hours if hired before 7/1/95) are eligible on their first day actively at work.

Enrollment through the FLEX WEB Enrollment must be made within 15 days from the date of hire.

As noted above, medical eligibility is determined by your home Zip Code. Follow the instructions listed above to determine the plans you are eligible to select.

In addition, you can enroll your dependents by selecting Associate plus One or Family coverage. Eligible dependents include:

- ❖ Your spouse, unless you are legally separated
- ❖ Your unmarried, dependent children to the age of 19
- ❖ Your unmarried, dependent children between the ages of 19 and 25, if they are full-time students at an accredited college, school, or university
- ❖ Your unmarried, dependent children age 19 or older and currently covered under the Plan that are physically or mentally disabled and are incapable of earning their own living. (Onset of disability must be prior to age 19 or while covered under the Plan.) This is subject to the Plan's approval by completing the

"Incapacitated Dependent Information" form (located on the Forms Library of the Associate Portal) within 31 days of the date their coverage would end.

The term "dependent" as it applies to coverage refers only to a person who is dependent on you (or your same-sex domestic partner) for more than one-half of his or her financial support. Healthcare benefits provided to your dependent children are tax free; as long as your children qualify as dependents within the meaning of section 152 of the Internal Revenue Code (this provision defines your tax dependents based on several criteria, including age, relationship, place of residence and source of support). If your children do not qualify as dependents under the Internal Revenue Code, the fair market value of the coverage provided to those children is considered taxable income to the associate. Please contact your tax advisor if you have any questions about whether your children qualify as dependents under the Internal Revenue Code.

Note: If a dependent (other than a newborn child) is confined for medical care or treatment in a hospital, extended care facility, or at home on the date coverage would become effective, then such coverage will be effective regardless of the confinement.

The term "children" as it applies to coverage includes:

- ❖ Your biological children
- ❖ Any legally adopted children or children placed with you for adoption or for whom the ADP associate has financial responsibility as established by pre-adoption court decree
- ❖ Stepchildren who reside in your household **a minimum of 50% of the time** and are dependent on you for their principal support and maintenance
- ❖ Adopted or foster children who reside in your household **a minimum of 50% of the time** and are dependent on you for their principal support and maintenance; additionally, the ADP associate must have a higher adjusted gross income than any natural parent, be older than the adopted or foster child, and no natural parent may claim the child as a dependent for tax purposes
- ❖ Children who reside in your household for whom the ADP associate has been named legal guardian and is required to provide medical care. This is subject to the plan's approval by completing the "Non Standard Dependent Information" form (located on the Forms Library of the Associate Portal) within 31 days of the date their coverage would end.

The term "spouse" as it applies to coverage refers to a person of the opposite sex to whom you are legally married or with whom you live in a legal common law marriage. ADP will recognize a spouse from a legal common law marriage only if all of the following criteria are satisfied:

- ❖ First, the associate's common law marriage must be established in a state that recognizes common law marriage, and the associate and the common law spouse must satisfy all criteria required to establish a common law marriage in that state.
- ❖ Second, the associate and his or her common law spouse must cohabit in a state which recognizes common law marriage.
- ❖ Third, the associate and his or her common law spouse must "hold themselves out as husband and wife." They must tell the world that they are husband and wife through their conduct, such as the woman's assumption of the man's surname, filing a joint federal income tax return, etc.
- ❖ Fourth, the associate must complete and submit a Certification of Common Law Marriage at the time of initial enrollment and annually at each subsequent open enrollment, certifying that the associate and the common law spouse are validly married.

As part of the initial and annual requirement to submit a Certification of Common Law Marriage, the associate will be required to provide proof of the common law marriage. Proof of the common law marriage may be provided in the form of a written declaration or administrative order from the state in which the common law marriage was established (for those states that issue such documentation). In addition, the associate and his or her common law spouse must produce his or her most recent federal income tax returns indicating that the associate and his or her common law spouse filed either as "married filing jointly" or as "married filing separately." ADP retains the right to request proof of an associate's filing status at any time. The associate must also produce, if such exists, any evidence of an agreement to be married.

The Certification of Common Law Marriage form can be obtained by contacting the ADP Benefits Hotline at 800-735-0350.

Note: No one can be covered more than once under this Plan as both an associate and a dependent or as a dependent of more than one employee.

Same-Sex Domestic Partner

You may enroll your same-sex domestic partner and the children of your same-sex domestic partner for medical benefits subject to certain eligibility and enrollment rules as defined under the plan. Associate contributions to cover a same-sex domestic partner and the eligible children of a same-sex domestic partner are the same as to cover a spouse and children; however there may be additional tax consequences for the associate.

You are required to complete a Certification of Domestic Partnership and Declaration of Tax Status to enroll. Refer to the General Information Section of the Summary Plan Description for detailed information on the same-sex domestic partner benefit guidelines or you can access the ADP Domestic Partner Policy on the Associate Portal under Benefits.

Associates not eligible for benefits include:

- ❖ Temporary associates, seasonal associates or independent contractors. Persons who are employed by the Company on a full or part-time basis, with the understanding that his or her employment will be terminated no later than upon completion of a specific assignment or date. A temporary associate may be offered and may accept a new temporary assignment with ADP and retain his or her status as a temporary associate.
- ❖ An individual designated by the Company as a worksite employee without regard to any subsequent determination or characterization by the Internal Revenue Service or other government agency or court that such an individual is a common law employee of the Company.
- ❖ An associate covered by a collective bargaining agreement unless such agreement expressly provides for coverage by the Plan.
- ❖ An associate designated by the Company as a Leased Employee under Code Section 414(n) without regard to any determination or characterization by the Internal Revenue Service or other government agency or court.

Things to Consider

- ❖ Are you willing to exclusively see doctors within an established network of providers (HMO) or do you need the flexibility to see other doctors that may be outside the network (Choice POS II / Choice Plus)?
- ❖ Which plan provides the best coverage for any special medical condition you or your family members may have?
- ❖ Is it important that you be able to predict your health care expenses? HMO's generally do not require you to pay an annual deductible or a percentage of your expenses - you pay only a small copay for services.
- ❖ Some HMOs do not cover dependent children to age 25. Check with your HMO for details.
- ❖ If you need to cover dependents that reside in another state, the Choice POS II / Choice Plus Plans offer the most flexibility. Many HMOs do not cover dependents residing out of the home area.

Choice POS II / Choice Plus Medical Options 1 & 2

How the Aetna Choice POS II and UHC Choice Plus Work

Both the Aetna Choice POS II and UHC Choice Plus plans include doctors, nurses, clinics, hospitals, and other licensed sources of health care that have contracted with Aetna or United Healthcare to provide services. You choose whether or not to use the Choice POS II / Choice Plus at the time you need medical services. You do not need to choose a primary care physician at enrollment.

Certain providers at a participating hospital may not be a part of the Choice POS II or Choice Plus network. These providers can include: Radiologists; Anesthesiologists; Pathologists, and Emergency Room Physicians. Services performed by a non-participating provider at a Choice POS II or Choice Plus hospital are not considered in-network; however, they are payable at the network level based on billed charges.

Network Providers

How they are identified and paid. Whose responsibility is it to determine network?

Covered expenses are the actual cost to the covered person of the usual and prevailing charge for covered services and supplies listed in this Plan Summary. The Claim Administrator, in its discretion, will calculate covered expenses following evaluation and validation of all provider billings in accordance with:

- ❖ The methodologies in the most recent edition of the Current Procedural Terminology
- ❖ The methodologies as reported by generally recognized professionals or publications

The covered expenses must be incurred for the care of an accidental injury or sickness. A covered expense is incurred on the date that the covered service or supply is performed or given. A covered person and his or her physician decide which services and supplies are given, but this Plan only pays for the covered services and supplies as determined by our Claim Administrator.

Covered services and supplies also include services and supplies that are part of an Alternate Care Proposal (ACP). An ACP is a course of treatment developed by the Claim Administrator and authorized by ADP as an alternative to the services and supplies that would otherwise have been considered covered services and supplies.

Unless the ACP specifies otherwise, the provisions of the Plan related to benefit amounts, maximum amounts, co-payments and deductibles will apply to these services.

Each covered person must satisfy certain co-payments and/or deductibles before any payment is made for certain covered services and supplies. Then the Medical Benefits pays the percentage of covered expenses shown in the Medical Options At-A-Glance Charts.

Co-payments and Deductibles

A co-payment is the amount of covered expenses the covered person must pay for certain medical provider services. Covered persons using Network Providers must pay the co-payment at the time services are given. These co-payments do not count toward the Network deductible.

The deductible is the amount of covered expenses the covered person must pay before Medical Benefits are payable. After the deductible has been met, covered expenses are payable at the percentage shown on the applicable Medical Options-At-A-Glance Chart.

A covered expense can only be used to satisfy a co-payment and/or deductible.

Office Visit Co-payment

The office visit co-payment applies to network physician's services. It applies only to the office visit expense in connection with each visit. Any other ancillary services, surgical procedures, or supplies are subject to the deductible and coinsurance.

Different co-payment amounts apply for Primary Care Physician services (PCP) versus Specialist Care Physician services (SCP). Your co-payment amount will depend on the plan option you elect and the type of provider rendering the care, either a PCP or SCP. A PCP is a general or family care practitioner, an internist, a pediatrician or obstetrician/gynecologist. All other providers are considered specialists under the plan. See the Medical Options-At-A-Glance summaries and the Definitions section of the SPD for further details.

The office visit co-payment does not apply to covered network physical therapy, occupational therapy, speech therapy, or chiropractic manipulation care. These services are subject to deductible and coinsurance and any applicable benefit maximums.

The office visit co-payment will apply only to the initial prenatal and postnatal office visits to the network obstetrician/gynecologist who is primarily responsible for maternity care.

Individual Deductible

The individual deductible applies to all covered expenses except for network office visit co-payments, routine physical co-payments and covered preventive services. It applies each calendar year.

The following items do not apply toward the satisfaction of the deductible:

- ❖ Expenses for services or supplies not covered by this Plan
- ❖ Expenses for services or supplies in excess of the usual and prevailing fees
- ❖ The covered person's coinsurance share of expenses partially covered by this Plan
- ❖ The penalty for failure to obtain pre-certification

Non-Notification Penalty

The non-notification penalty applies to covered expenses if Case Management/Pre-certification is not notified as required.

Out-of-Pocket Feature

Covered expenses are payable at the percentage shown in the "Medical Options-at-a-Glance Charts" until any out-of-pocket maximum has been reached during a calendar year. Then, covered expenses are payable at 100% for the rest of that year except expenses for mental and nervous and substance abuse are not payable at 100%.

All covered expenses that the covered person pays count toward the out-of-pocket maximums with the exception of those shown below.

Covered expenses used to satisfy the following co-payments and/or deductibles do not count toward any of the out-of-pocket maximums. These co-payments still apply even after the applicable out-of-pocket maximum has been reached:

- ❖ Office visit or routine physical co-payments
- ❖ Non-notification penalty

Network Individual Out-of-Pocket Maximum

When the network Individual out-of-pocket maximum is reached for any one covered person in a calendar year, network covered expenses, other than those shown in the out-of-pocket feature are payable at 100% for that same person for the rest of that year.

Non-Network Individual Out-of-Pocket Maximum

When the non-network individual out-of-pocket maximum is reached for any one covered person in a calendar year, non-network covered expenses, other than those shown in the out-of-pocket feature are payable at 100% for that person for the rest of that year.

Note: Eligible expenses will be covered at 100% of the Usual & Prevailing fee. The amount(s) above Usual & Prevailing fee will be the responsibility of the covered person.

Maximum Lifetime Benefit Amount

A \$3,000,000 lifetime benefit maximum per covered individual applies under the Choice POS II / Choice Plus Medical and Prescription Drug Plans. This provision was effective January 1, 2002 and applies to claims processed on and after January 1, 2002.

Any lifetime maximum applicable under an HMO plan offered by ADP is separate from this lifetime maximum.

Additionally, specific limitations apply for some services, including chiropractic, mental and nervous benefits, and invitro fertilization. See the section "Covered Services in Choice POS II / Choice Plus Plan" for details.

Claims

All claims for benefits must be submitted within two years from the date of service. You may obtain claim forms from the Associate Portal at www.adpassociate.com. Click on Benefits, and then select Forms Library.

Medicare and the Medical Plan

Medicare is a health care program provided under Social Security. Before you reach your 65th birthday, contact the Social Security Administration office for information about how to enroll in Medicare. If an associate enrolls in Medicare, the ADP Plan will continue to be the primary carrier unless the associate advises their local HR group **in writing** that they have elected to have Medicare as their primary coverage. In that case, the associate **will not** be able to use the ADP Plan as a secondary coverage and must cancel their coverage under ADP's Plan.

If you or an eligible dependent become eligible for early Medicare (before age 65) due to total disability, the ADP Plan will be secondary to Medicare. If you do not apply for Medicare when you are eligible, claims will be processed as if you had enrolled in Medicare. You must apply for Medicare Part A and Part B in order to have complete coverage.

Managed Choice POS II / Choice Plus Options 1 an 2

Aetna Choice POS II or United HealthCare Choice Plus

Associates have the option to elect either the Aetna Choice POS II or the United Healthcare Choice Plus Plan.

Note: If you are not in the UHC Zip Code service area, you will not be permitted to elect the UHC plan.

The benefit plan design and contributions are the same for both networks. However, the plan administration will be different - either Aetna or UHC - and there will be a different network of participating hospitals, doctors, labs and other providers for each. Additionally, the list of procedures and treatments requiring pre-certification and the payment rules for certain non-participating mental health providers will vary between plan administrators. Visit the Aetna web site at <http://www.aetna.com> or UHC web site at <http://www.uhc.com> for a list of participating providers or contact the Corporate Benefits Hotline for assistance.

Please note that if your doctor leaves either network, you cannot change your option due to IRS guidelines that regulate these Plans. You may only make a change if you move outside the Choice POS II / Choice Plus service area or during the next Open Enrollment period. You will not be permitted to alternate between the networks during the year.

Managed Options 1 and 2 provide coverage through a network of physicians, hospitals and other health care providers, who have contracted with the plan to provide comprehensive, quality service at a discount. You have the flexibility each time you receive service to use an in-network provider or out-of-network provider. Under both options, when you use a provider in the Choice POS II / Choice Plus network, you get the benefit of negotiated discounts. If you choose a provider outside the network, your out-of-pocket costs will be higher. Both options protect you against unexpected medical expenses and provide you the freedom to choose any provider.

Option 1 has a lower deductible and higher contribution. Option 2 has a lower contribution; however, you have higher deductible and out-of-pocket costs.

Note: Where a provider is not available within the network or if an associate is traveling outside the network service area and a non-network provider is used, the passive benefit of 80% usual and prevailing will apply to services of the non-network provider, subject to the in-network level deductible and out-of-pocket limits.

If an associate is traveling outside the U.S. and requires medical care, passive PPO benefits will apply. Associates enrolled in an HMO plan should contact the HMO for coverage information while traveling outside the country.

Health Information/Nurseline Services

Both Aetna and UHC provide health information services for associates and their families enrolled in Aetna Choice POS II and UHC Choice Plus Plans. The Aetna program is called Informed Health Line (800-556-1555) and the UHC program is Optum Nurseline (866-317-6369). Among the services included are:

- ❖ 24 hours a day / 365 days a year nurseline service which allows you to talk to a registered nurse to obtain information on a variety of health and wellness topics, as well as information that can help you choose care that is appropriate for your situation
- ❖ Access to on-line and audio health information libraries
- ❖ Advice on self-care measures and tips on communicating with your health care provider

This is a valuable resource that can assist you in making intelligent choices about your healthcare.

Aetna Choice POS II & UHC Choice Plus Medical Options-At-A-Glance

Choice POS II / Choice Plus	Option 1		Option 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (In-network & Out-of-network deductible cross applies) Per Person/Family	\$325 / \$800	\$575 / \$1,425	\$1,100 / \$2,750	\$1,600 / \$4,000
Annual Out-of-Pocket Limit (Includes deductible. Does not include copays or out-of-network amounts over the U&P fee Per Person/Family	\$2,000 / \$4,000	\$4,500 / \$9,000	\$3,250 / \$7,000	\$7,000 / \$14,750
Lifetime Benefit Maximum	\$3 million per individual Combined in and out of network expenses Includes medical and prescription drugs		\$3 million per individual Combined in and out of network expenses Includes medical and prescription drugs	
Office Visits Primary Care Physician (General Practitioner, Family Practitioner, Internist, Pediatrician & OB/GYN)	\$20 copay per office visit, other services covered at 80% after deductible	60% U&P Deductible applies	\$30 copay per office visit, other services covered at 80% after deductible	60% U&P Deductible applies
Specialist	\$30 copay per office visit, other services covered at 80% after deductible	60% U&P Deductible applies	\$40 copay per office visit, other services covered at 80% after deductible	60% U&P Deductible applies
Mental & Nervous Benefits (1) Outpatient (maximum combined for in and out-of-network is 50 visits per calendar year)	Maximum of 50 visits at \$30 copay (not subject to deductible)	Maximum of 50 visits at 50% of U&P Fee after deductible has been satisfied	Maximum of 50 visits at \$40 copay (not subject to deductible)	Maximum of 50 visits at 50% of U&P Fee after deductible has been satisfied
Inpatient (maximum is 30 days per calendar year)	80% after deductible	60 % U&P after deductible	80% after deductible	60% U&P after Deductible
Hospital Emergency Room for Urgent Care Hospital-based providers	\$75 copay plus 80% after deductible	\$75 copay plus 80% U&P after deductible Copay waived if admitted	\$75 copay plus 80% after deductible	\$75 copay plus 80% U&P after deductible Copay waived if admitted
Note: Urgent Care is treatment for a life-threatening condition or one that could permanently impair a bodily function.				
Physical, Speech and Occupational Therapy (6))	80% after deductible	60% U&P after deductible	80% after deductible	60% U&P after deductible
Chiropractor	80% after deductible up to a maximum benefit of \$2500 per calendar year	60% U&P after deductible up to a maximum benefit of \$2500 per calendar year	80% after deductible up to a maximum benefit of \$2500 per calendar year	60% U&P after deductible up to a maximum benefit of \$2500 per calendar year
X-Ray / Lab	80% after deductible	60% U&P after deductible	80% after deductible	60% U&P after deductible
Preventive Care (Deductible Waived) Routine Cancer Screenings Routine Physical for Adults (5) (age 18 through 64: 1 every 24 months) (age 65 and above: 1 every 12 months) Immunizations (2) (through age 17)	Covered at 80% \$20 copay per office visit	Not Covered	Covered at 80% \$30 copay per office visit	Not Covered
Well-Baby and Well-child Visits Well-Baby (through age 5) Well-Child (ages 6 through 17): 1 visit Every 24 months	Covered 100% when part of a well-child/well-baby visit. Covered at 80% when not part of a physician office visit	Not Covered Not Covered	Covered 100% when part of a well-child/well-baby visit. Covered at 80% when not part of a physician office visit	Not Covered Not Covered
Prescription Drug (Medco)	Option 1 and Option 2		Home Delivery Pharmacy Service Up to a 90-day supply	
Generic Drugs	25% of the prescription drug's total cost No less than \$10 (3) No more than \$50		25% of the prescription drug's total cost No less than \$25 / No more than \$100	
Brand-name Drugs (4)	25% of the prescription drug's total cost No less than \$25 (3) / No more than \$80		25% of the prescription drug's total cost No less than \$55 / No more than \$160	
Note: Plan payment based upon cost of generic when available.				
Bi-Weekly Associate Contributions	\$43.60 \$96.00 \$160.30		\$14.70 \$32.10 \$61.10	

See Footnotes (1-6) on the next page.

- 1) After the out-of-pocket maximums are reached, benefits for mental disorder treatment are not payable at 100%
- 2) Well-child immunizations include the following: diphtheria, pertussis, tetanus, hemophilus influenza, oral polio, hepatitis A, hepatitis B, measles, mumps, rubella, chicken pox, meningitis and one tuberculosis skin test.
- 3) If the cost of the drug is less than the minimum copay, you will only pay the actual cost
- 4) If you purchase a brand name medication when a generic equivalent is available, you will pay your **generic copay plus the cost difference between the brand name and generic medication**
- 5) Covered services for routine physicals include only age and gender appropriate clinical screenings and immunizations in accordance with guidelines followed by Aetna and UHC network providers
- 6) Therapy services for developmental delay are available for dependent children age 18 months to age 5 only; subject to 20 visit maximum per calendar year

Special features of your Plan:

- ❖ If you purchase a brand-name medication when a generic equivalent is available, you will pay your **generic copay plus the cost difference between the brand name and generic medication**
- ❖ ADP will pay up to \$100 for smoking cessation medications. You are still responsible for your copay amounts. This is a lifetime benefit limit. After reaching this limit, you will be responsible for paying the entire cost of the prescription drugs. This benefit consists of the amount ADP pays for prescription drugs, exclusive of your copay amounts
- ❖ Some drugs are subject to prior authorization rules. Your doctor may be required to provide additional information before prescriptions for these medications can be filled. See the Prescription section for a complete list
- ❖ Long-term (maintenance) drugs are subject to higher member cost-share if purchased at retail instead of mail. Refer to the Retail Refill Allowance Program in the Prescription section for details

Passive PPO Options 1 and 2

The Passive PPO Options are only available to associates who reside outside of the Aetna Choice POS II and United Healthcare PPO managed care service areas. Passive benefits are available through Aetna only. (United Healthcare is not an option for Passive PPO at this time.) Under the Aetna Passive PPO options, out-of-network benefits are paid at a higher level than the standard managed plan benefits (80% coinsurance vs. 60%). The deductible and out-of-pocket maximums are the same as the network benefit levels.

For associates traveling out of the country who require medical care, you will be eligible for Passive PPO benefits through either Aetna or UHC.

To determine your Plan eligibility, go to www.adpassociate.com. If you have not registered yet for web enrollment, you will need to register. See Flex Web Enrollment Section of this Brochure. Once registered, log on to www.adpassociate.com with your associate ID and the password you created when you registered. If you forgot your password, click on "Forgot password." Click on Benefits and then 2009 Plan Information, and then click on "Medical/Dental Plans and Rates." Enter home zip code, or you can contact the Corporate Benefits Hotline at 800-735-0350 for assistance.

Aetna Medical Options-At-A-Glance (Passive)

PPO	Option 1-Passive PPO Only In-Network Out-of-Network	Option 2 – Passive PPO Only In-Network Out-of-Network		
Annual Deductible – In-network & Out-of-network deductible cross apply Per Person/Family	\$325 / \$800	\$1,100/ \$2,750		
Annual Out-of-Pocket Limit (Includes deductible. Does not include co-pays or out-of-network amounts over the U&P fee) Per Person/Family	\$2,000 / \$4,000	\$3,250 / \$7,000		
Lifetime Benefit Maximum	\$3 million per individual Combined in and out of network expenses Includes medical and prescription drugs	\$3 million per individual Combined in and out of network expenses Includes medical and prescription drugs		
Office Visits Primary Care Physician (General Practitioner, Family Practitioner, Internist, Pediatrician & OB/GYN)	\$20 copay per office visit, other services covered at 80% after deductible	80% U&P Deductible applies	\$30 copay per office visit, other services covered at 80% after deductible	80% U&P Deductible applies
Specialist	\$30 copay per office visit, other services covered at 80% after deductible	80% U&P Deductible applies	\$40 copay per office visit, other services covered at 80% after deductible	80% U&P Deductible applies
Mental & Nervous Benefits (1) Outpatient (maximum combined for in and out-of-network is 50 visits per calendar year) Inpatient (maximum is 30 days per calendar year)	Maximum of 50 visits at \$30 copay (not subject to deductible) 80% after deductible	Maximum of 50 visits at 50% of U&P Fee after deductible has been satisfied 80% U&P after deductible	Maximum of 50 visits at \$40 copay (not subject to deductible) 80% after deductible	Maximum of 50 visits at 50% of U&P Fee after deductible has been satisfied 80% U&P after deductible
Hospital Emergency Room for Urgent Care Hospital-based providers	\$75 copay plus 80% after deductible Note: Urgent Care is treatment for a life-threatening condition or one that could permanently impair a bodily function.	\$75 copay plus 80% U&P after deductible Copay waived if admitted	\$75 copay plus 80% after deductible Copay waived if admitted	\$75 copay plus 80% U&P after deductible Copay waived if Admitted
Physical, Speech and Occupational Therapy (6)	80% after deductible	80% U&P after deductible	80% after deductible	80% U&P after deductible
Chiropractor	80% after deductible up to a maximum benefit of \$2500 per calendar year	80% U&P after deductible up to a maximum benefit of \$2500 per calendar year	80% after deductible up to a maximum benefit of \$2500 per calendar year	80% U&P after deductible up to a maximum benefit of \$2500 per calendar Year
X-Ray / Lab	80% after deductible	80% U&P after deductible	80% after deductible	80% U&P after deductible
Preventive Care (Deductible Waived) Routine Cancer Screenings Routine Physical for Adults (5) (age 18 through 64: 1 every 24 months) (age 65 and above: 1 every 12 months) Immunizations (2) (through age 17)	Covered at 80% \$20 copay per office visit Covered 100% when part of a well-child/well-baby visit. Covered at 80% when not part of a physician office visit	80% of U&P 80% of U&P 80% of U&P	Covered at 80% \$30 copay per office visit Covered 100% when part of a well-child/well-baby visit. Covered at 80% when not part of a physician office visit	80% of U&P 80% of U&P 80% of U&P
Well-Baby and Well-child Visits Well-Baby (through age 5) Well-Child (ages 6 through 17): 1 visit Every 24 months	\$20 copay per office visit	80% of U&P	\$30 copay per office visit	80% of U&P
Prescription Drug (Medco)	Option 1 and Option 2		Home Delivery Pharmacy Service	
Generic Drugs	Retail network pharmacy Up to a 30-day supply 25% of the prescription drug's total cost No less than \$10 (3) No more than \$50		Up to a 90-day supply 25% of the prescription drug's total cost No less than \$25 (4) / No more than \$100	
Brand-name Drugs (4)	25% of the prescription drug's total cost No less than \$25 (3) / No more than \$80		25% of the prescription drug's total cost No less than \$55 (4) / No more than \$160 Note: Plan payment based upon cost of generic when available.	
Bi-Weekly Associate Contributions	\$43.60 \$96.00 \$160.30		\$14.70 \$32.10 \$61.10	

See Footnotes (1-6) on the next page.

- 1) After the out-of-pocket maximums are reached, benefits for mental disorder treatment are not payable at 100%
- 2) Well-child immunizations include the following: diphtheria, pertussis, tetanus, hemophilus influenza, oral polio, hepatitis A, hepatitis B, measles, mumps, rubella, chicken pox, meningitis and one tuberculosis skin test.
- 3) If the cost of the drug is less than the minimum copay, you will only pay the actual cost
- 4) If you purchase a brand name medication when a generic equivalent is available, you will pay your **generic copay plus the cost difference between the brand name and generic medication**
- 5) Covered services for routine physicals include only age and gender appropriate clinical screenings and immunizations in accordance with guidelines followed by Aetna and UHC network providers
- 6) Therapy services for developmental delay are available for dependent children age 18 months to age 5 only; subject to 20 visit maximum per calendar year

Special features of your plan:

- ❖ If you purchase a brand-name medication when a generic equivalent is available, you will pay your **generic copay plus the cost difference between the brand name and generic medication**
- ❖ ADP will pay up to \$100 for smoking cessation medications. You are still responsible for your copay amounts. This is a lifetime benefit limit. After reaching this limit, you will be responsible for paying the entire cost of the prescription drugs. This benefit consists of the amount ADP pays for prescription drugs, exclusive of your copay amounts
- ❖ Some drugs are subject to prior authorization rules. Your doctor may be required to provide additional information before prescriptions for these medications can be filled. See the Prescription section for a complete list
- ❖ Long-term (maintenance) drugs are subject to higher member cost-share if purchased at retail instead of mail. Refer to the Retail Refill Allowance Program in the Prescription section for details

Case Management/Pre-Certification Program

The Case Management/Pre-Certification Program is designed to encourage an efficient system of care for associates and their enrolled dependents by identifying and addressing certain covered health care needs; such as admission counseling, inpatient care advocacy and certain discharge planning and disease management activities. The Case Management/Pre-Certification activities are not a substitute for the medical judgment of your physician. However, the ultimate decision as to what medical care associates or their dependents actually receive must be made by the associate and their physician.

Case Management/Pre-certification is triggered when the Plan Administrator receives notification of an upcoming treatment or service. The notification process serves as a gateway to Case Management/Pre-certification activities and is an opportunity for the associate to let the Plan Administrator know that they are planning to receive specific health care services.

The associate can expect to receive phone calls from the Plan Administrator when certain treatments are involved.

When using a non-network provider, it is the associate's responsibility to make sure that the Plan Administrator is notified, as required.

If an associate fails to follow the notification requirements set forth in this section a Non-Notification Penalty will be imposed after the deductible has been satisfied. This amount will not be counted when satisfying the out-of-pocket maximum.

How to Notify Case Management/Pre-Certification

Call the toll-free number shown on your ID card.

When to Notify Case Management/Pre-Certification

Hospital Pre-certification

If you or a participating member of your family is considering hospitalization, ADP's preadmission review administrator must be contacted before admission. If you do not follow the preadmission procedures or the administrator's recommendations, the benefit payable for hospital expenses is reduced by \$500.

The associate, a member of the associate's family, the doctor, or any designated individual may make the contact. The responsibility for making the contact is yours. The administrator determines the length of inpatient care that is eligible for benefits under the Plan. This means that days not approved are not covered under the Plan.

If you are hospitalized in an emergency situation, you must notify the administrator within two business days of the admission. By working with your doctor throughout your hospital stay, the administrator can make a sound recommendation on the length of stay that is eligible for benefits under the Plan.

- ❖ For inpatient confinement, the covered person must notify Case Management/Pre-certification of the scheduled admission date at least five (5) working days before the start of the confinement. An admission date may not have been set when the confinement was planned. The covered person must call Case Management/Pre-certification again as soon as the admission date is set

For outpatient services that require notification, the covered person must notify Case Management/Pre-certification at least five (5) working days before the service is given.

Aetna Choice POS II List of Procedures and Treatments Requiring Pre-certification for Aetna Choice POS II Members:

- ❖ **Inpatient confinements:** Surgical and non-surgical, mental and nervous, skilled nursing facility, rehabilitation facility, inpatient hospice and maternity confinements.
- ❖ **Transplantation**
- ❖ **Home health services**
- ❖ **Cosmetic and Reconstructive Procedures**
 - Blepharoplasty, Canthopexy, Canthoplasty
 - Excision of excessive skin due to weight loss
 - Tattoo removal, revision or application
 - Rhinoplasty; rhytidectomy
 - Gastroplasty; gastric bypass
 - Pectus Excavatum, repair
 - Breast Reconstruction; breast enlargement
 - Breast reduction; mammoplasty
 - Surgical treatment of gynecomastia
 - Lipectomy or excess fat removal
 - Treatment of penile dysfunction
 - Sclerotherapy or surgery for varicose veins
 - Any other cosmetic procedure

Selected Durable Medical Equipment

- Electric and motorized wheelchairs and scooters
- Clintron and electric beds
- Customized braces
- Limb and torso prosthetics

❖ **Medical Injectables**

- Growth hormone
- Intravenous immunoglobulin (IVIG)
- ❖ **Other Surgery/Services**
 - Uvulopalatopharyngoplasty, including laser assisted procedures
 - Orthognathic surgery procedures, osteotomies and surgical management of the temporomandibular joint
 - Laparoscopic infertility surgery
 - Bunionectomy and hammertoe
 - Elective (non-emergent) transportation by ambulance, medical van or air ambulance
 - Investigative or experimental services

United Healthcare (UHC) Choice Plus List of Procedures and Treatments Requiring Pre-certification for UHC Choice Plus Members:

- ❖ Any inpatient hospital confinement or any skilled nursing facility
- ❖ Any home health care
- ❖ Private duty nursing
- ❖ Organ / tissue transplant

You may also be required to have an independent medical exam by a physician who is:

- ❖ Certified by an appropriate specialty board and
- ❖ Not in practice with the physician recommending the procedure or treatment.

The results of the exam will help determine the necessity of the procedure or treatment. Expenses incurred for such exam will be payable at 100% with no calendar year deductible.

Note: You or the provider performing the procedure or treatment must call the toll-free number shown on your ID card to request certification.

Benefits Reduced if Case Management/Pre-Certification Not Called

Benefits are reduced if the covered person does not call as required. A non-notification penalty applies to each confinement, surgical procedure or treatment plan if services are medically necessary. The amount of the penalty is \$500 per confinement or procedure. The amount of the penalty will never be more than the covered expense. No benefits will be paid if services are not medically necessary.

A Covered Person can appeal a Review decision by calling Case Management/Pre-certification

If the covered person or the physician does not agree with the decision, it can be appealed. See complete details of the appeals process in the ERISA section of this SPD.

Maternity Case Management

Pregnancy is subject to the following notification time periods:

- A. **Prenatal Program** - Case Management/Pre-certification should be notified during the first trimester (12 weeks) of pregnancy. This early notification makes it possible for the mother to participate in the prenatal programs available through Aetna or UHC as described below.
- B. **Inpatient Confinement for Delivery of a Child** - Case Management/Pre-certification must be notified only if the inpatient care for the mother or child is expected to continue beyond:
 - ❖ 48 hours following a normal vaginal delivery, or
 - ❖ 96 hours following a Cesarean section

For inpatient care (for either the mother or child) which continues beyond the 48/96-hour limits stated above, the Case Management/Pre-certification must be notified before the end of these time periods.

C. Non-emergency Inpatient Confinement without Delivery of Child - Confinement during pregnancy but before the admission for delivery, which is not Emergency Care, requires notification as a scheduled confinement. Case Management/Pre-certification must be notified prior to the scheduled admission.

Beginning RightSM Maternity Program (Aetna) (800-272-3531) – formerly Moms to Babies Maternity Management Program

This maternity program is available to ADP associates enrolled in the Aetna Choice POS II medical options.

The Beginning Right Maternity Program provides you with maternity health care information, and guides you through pregnancy. This program provides:

- ❖ Educational materials on prenatal care, labor and delivery, postpartum depression and breastfeeding
- ❖ Specialized information for Dad or partner
- ❖ Web-based materials and access to program services through Women's Health Online
- ❖ Care coordination by trained obstetrical nurses
- ❖ Access to Smoke-free Moms-to-be® smoking cessation program for pregnant women
- ❖ Preterm labor education
- ❖ Access to breastfeeding support services

Another important feature, **Pregnancy Risk Assessment**, identifies women who may need more specialized prenatal and/or postnatal care due to medical history or present health status. If risk is identified, the program assists you and your physician in coordinating any specialty care that may be medically necessary.

Healthy Pregnancy Program (UHC) (800-411-7984)

The Healthy Pregnancy Program is an educational program for expectant mothers sponsored by United Healthcare. The program is based on the guidelines created by the American College of Obstetrics and Gynecology (ACOG) and works to assist in the early identification of women who are at increased risk for premature labor and premature delivery. The program encourages doctor-patient discussions and healthy behavior during pregnancy, and provides information that will increase awareness of pregnancy-related issues. Members may reach Health Pregnancy by dialing 800-411-7984.

Medical Management Programs

Case Management (Aetna) (800-648-4092)

This program is available to Aetna Choice POS II and Passive PPO members. Case Management focuses on improving health and wellness. Case Management is a process of identifying persons at high risk for problems associated with complex healthcare needs, assessing opportunities to coordinate care, and identifying treatment options to improve quality of care, quality of life, and control costs. Case Managers generally assist members in managing their illnesses, coordinate a series of intensive interventions designed to alter the natural history of a specific illness and facilitate the accessibility of resources. By integrating the record of a member's contact with the medical delivery system, Case Managers can focus internal and external resources in an effort designed to improve the individual member's clinical condition.

Care Coordination (UHC) (866-633-2474)

This program is available through the UHC Choice Plus plan. Care Coordination is United Healthcare's medical management program that focuses on high risk individuals and by nurse outreach, works with those individuals by closing gaps in care. Individuals are identified through a variety of "gateways" including notification to the plan of hospital admissions, home health needs and durable medical equipment. Members are also identified by incurred medical claims and the myuhc health assessment.

Once identified, a Care Coordination nurse makes an outbound call to the member's home to conduct an assessment of the member's healthcare needs. This call is the beginning of the relationship between the nurse and the member. Together, they work as a team to close gaps in care such as setting up regular physician appointments, medication management and education, questions to ask during physician visits, etc. The role of the nurse is to partner with the member to manage the illness or condition.

Covered Services in Choice POS II / Choice Plus Plans

Acupuncture Therapy

Acupuncture therapy is not covered, except when it is performed by a physician as a form of anesthesia in connection with surgery that is covered under this Plan.

Ambulatory Surgical Center Services

Include services that are given within 72 hours before or after a surgical procedure. The services must be given in connection with the procedure.

Anesthetics

Charges of a physician or professional anesthetist for furnishing and administering anesthetics are covered.

Convalescent Facility

Medically necessary services received in a convalescent, extended care, or skilled nursing facility. Benefits will be paid for up to 60 days during any one convalescent period. This benefit does not cover charges made for the treatment of: drug addiction, chronic brain syndrome, alcoholism, senility, mental retardation, and other mental disorder. Custodial care and non-skilled medical services are not covered.

Confinement in a convalescent facility is covered when:

- ❖ The confinement is recommended by a doctor and begins during a convalescent period
- ❖ The patient is under the continuing care of a doctor
- ❖ The patient receives necessary skilled nursing care, physical rehabilitation services, or both, and it is expected that the care received will improve the patient's condition and facilitate discharge

A convalescent facility, extended care facility or skilled nursing facility is eligible if the facility:

- ❖ Is recognized as a skilled nursing facility by Medicare
- ❖ Is licensed to provide inpatient skilled nursing and physical restoration services
- ❖ Is supervised by a doctor or RN
- ❖ Provides 24-hour care by a staff of licensed nurses under the direction of a full-time RN
- ❖ Keeps complete medical records on each patient
- ❖ Has a utilization review plan for each patient
- ❖ Makes charges to its patients
- ❖ Is not mainly a place for rest, the aged, drug addicts, alcoholics, custodial or educational care, or for care of mental retardation or mental disorders

Durable Medical Equipment

Durable Medical Equipment means equipment, which meets all of the following:

- ❖ It is for repeated use and is not a consumable or disposable item
- ❖ It is used primarily for a medical purpose
- ❖ It is appropriate for use in the home

Some examples of Durable Medical Equipment are:

- ❖ Appliances which replace a lost body organ or part or help an impaired one to work
- ❖ Orthotic devices such as arm, leg, neck, and back braces
- ❖ Hospital-type beds
- ❖ Equipment needed to increase mobility, such as a wheelchair
- ❖ Respirators or other equipment for the use of oxygen
- ❖ Monitoring devices

The Plan Administrator decides whether to cover the purchase or rental of the equipment. Repair or replacement of purchased equipment is covered, if it is needed due to a change in person's physical condition, or if it would cost less to replace than to repair or rent the equipment.

Hearing Care

- ❖ **Hearing Aids** - Covered services are limited to charges for hearing aids required as result of an accident or illness up to a maximum of \$1,000 per device every 36 months. Not covered due to a degenerative condition.
- ❖ **Cochlear Implants** - Covers expenses for unilateral cochlear implant procedure for severe hearing loss or other medically indicated conditions. In addition to the surgical implant procedure, eligible expenses include the cochlear implant device (internal and external components) and auditory rehabilitation therapy following the implant procedure. The Plan does not cover bilateral cochlear implants.

Only those conditions and services determined to be medically necessary and appropriate by the Claim Administrator will be eligible under this benefit.

Home Health Care

The following covered services must be given by a Home Health Care Agency:

- ❖ Temporary or part-time nursing care by or supervised by a registered graduate nurse (RN)
- ❖ Temporary or part-time care by a home health aide
- ❖ Physical, occupational, or speech therapy

Covered Services are limited to 50 visits each calendar year with a per visit maximum of \$100 (each period of home health aid care of up to four hours given in the same day counts as one visit). Each visit by any other member of the home health team will count as one visit.

Hospice care

Expenses for care incurred when a person or dependent has a life expectancy of 12 months or less as certified by their primary attending physician. Eligible expenses include room and board, social services, home health aids, nurses, consulting services, family counseling sessions, and bereavement counseling for up to three months. If the patient outlives the 12 month prognosis, the Plan may extend this benefit.

Hospital Services

- ❖ **Room and Board** - Covered expenses for a private room are limited to the regular daily charge made by the hospital for a semi-private room
- ❖ **Other Services and Supplies**
- ❖ **Emergency Room** - Covered services only if it is determined that the services are covered health services and there is not a less intensive or more appropriate place of service, diagnostic or treatment alternative that could have been used in lieu of emergency room services

If the Plan Administrator, at its discretion, determines that a less intensive or more appropriate treatment could have been given, then no benefits are payable. To receive full benefits you must call the number on your identification card for pre-certification.

Infertility Treatment

Even though not incurred for the treatment of a disease or injury, covered medical expenses will include expenses incurred for the following on the same basis as for disease: The Plan will pay for eligible charges incurred by an associate or associate's spouse for medically needed non-experimental invitro fertilization, artificial insemination, gamete (GIFT) and zygote (ZIFT) intrafallopian transfer procedures up to an annual maximum of \$5,000. Costs included in the \$5,000 limit are all expenses related to a covered infertility treatment procedure once a diagnosis of infertility has been made. Costs excluded from the \$5000 limit are the diagnostic consultations and necessary testing to diagnose infertility and drug therapy expenses.

Approved prescription drugs for the treatment of outpatient infertility are covered through the Choice POS II / Choice Plus Prescription Plan and are subject to the Medco pre-authorization rules.

IUD Device

Expenses for IUD for treatment of heavy menstrual bleeding. This includes costs for insertion, removal and the device itself. IUD for birth control or any other medical condition is not covered as specified in Expenses Not Covered under Choice POS II / Choice Plus Plans later in this section.

Lab Tests and Allergy Tests for Diagnosis or Treatment

Medical services and supplies such as x-ray and laboratory fees, oxygen, radium, blood or blood plasma (that is not donated or otherwise replaced), rental of an iron lung and other such equipment, and prosthetic appliances (in some circumstances).

Medical Transportation Services

Transportation by professional ambulance, other than air ambulance, to and from a medical facility. Transportation by regularly scheduled airline, railroad or air ambulance, to the nearest medical facility qualified to give the required treatment. These services must be given within the United States, Puerto Rico, or Canada.

Mental and Nervous Conditions and Substance Abuse

Benefits are payable for covered services and supplies for mental disorder treatment given to the covered person while covered under this Plan. There are 30 days of inpatient care covered per calendar year, which are subject to the deductible and coinsurance. Outpatient care is covered at \$30 co-pay Choice POS II / Choice Plus Option 1 and \$40 co-pay Choice POS II / Choice Plus Option 2 (not subject to deductible) for up to 50 visits per calendar year in-network. Out-of-network outpatient care is covered at 50% up to a maximum of 50 visits per calendar year. Maximum 50 visits covered when outpatient care is provided both in and out-of-network.

Deductibles and coinsurance amounts count toward the out-of-pocket maximums. For out-of-network and out-of-area benefits, the full usual and prevailing fee (except as noted below for Aetna) will be considered in determining the amount that will count toward the deductible and the out-of-pocket maximum. After the out-of-pocket maximums are reached, benefits for mental disorder treatment are not payable at 100%.

Beginning in 2008, the reimbursement policy for out-patient services by non-participating mental health providers will change under the Aetna plan. The Aetna provider reimbursement rate (allowable charge) will be based on the provider's licensing credentials as follows:

M.D. Psychiatrist	100% U & P amount
PH.D Psychologist	80% U & P amount
MSW Social Worker or Psychiatric Nurse	60% U & P amount

This means the Aetna determined allowable charge will be less for certain types of non-participating providers and will result in higher out-of-pocket expenses for the member because you will still be responsible for any difference between the provider's full fee and the Aetna allowable charge in addition to your 50% coinsurance and deductible under the ADP plan.

Inpatient Benefit Exchanges

When preauthorized by Aetna or UHC, 1 mental health inpatient day may be exchanged for up to 4 outpatient visits or 2 days of partial hospitalization. No more than 10 inpatient days can be exchanged in a Calendar Year. The benefit allows for the exchange of inpatient hospital days for outpatient visits. It applies to in-network providers only and authorization is required. This benefit is only available after the outpatient visit limit is met. Benefit exchange is limited to mental health and substance abuse services only and is only covered if medically necessary and determines that treatment will prevent the need for inpatient treatment.

Nurse-Practitioner Services

Services of a licensed or certified Nurse Practitioner acting within the scope of that license or certification.

Occupational Therapy

Services of a licensed occupational therapist provided the following conditions are met:

- ❖ The therapy must be ordered and monitored by a physician
- ❖ The therapy must be medically necessary for the care and treatment of an illness or injury
- ❖ The therapy must be given in accordance with a written treatment plan approved by a physician
- ❖ The therapist must submit progress reports at the intervals stated in the treatment plan
- ❖ The therapy must be expected to result in a significant, objective and measurable physical improvement in the covered person's condition within two (2) months of the start of the treatment

Therapy for developmental delay for a dependent child age 18 months to age 5 only is limited to 20 visits per calendar year. This limit does not apply to treatment of autism.

Oral Surgery and Dental Services

Expenses for the treatment of the mouth, jaws, and teeth are covered medical expenses, but only those for:

- ❖ Services rendered and supplies needed for the following treatment of or related to conditions of the:
 - Teeth, mouth, jaws, jaw joints or supporting tissues (this includes bones, muscles, and nerves)
 - Dental related hospital and anesthesia services for children under the age of six are eligible where medically necessary

For these expenses, "physician" includes a dentist.

Oral Surgical Services

Surgery needed to:

- ❖ Treat a fracture, dislocation, or wound
- ❖ Cut out:
 - Teeth partly or completely impacted in the bone of the jaw
 - Teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone
 - The roots of a tooth without removing the entire tooth
 - Cysts, tumors, or other diseased tissues
- ❖ Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth
- ❖ Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement

Non-surgical treatment of infections or diseases. This does not include those of or related to the teeth.

Note: Charges for oral surgery that are reimbursable (in whole or in part) under the Medical Plan are not eligible for benefits under the Dental Plan.

Accidental Injury to Teeth

Dental work, surgery and orthodontic treatment needed to remove, repair, replace, restore, or reposition:

- ❖ Natural teeth damaged, lost, or removed
- ❖ Other body tissues of the mouth fractured or cut
- ❖ Due to injury

Any such teeth must have been:

- ❖ Free from decay
- ❖ In good repair
- ❖ Firmly attached to the jawbone at the time of the injury

The treatment must be done in the calendar year of the accident or the next one, if the following are installed due to such injury:

- ❖ Crowns (caps)
- ❖ Dentures (false teeth)
- ❖ Bridgework
- ❖ In-mouth appliances

Covered Medical Expenses include only charges for:

- ❖ The first denture or fixed bridgework to replace lost teeth
- ❖ The first crown needed to repair each damaged tooth
- ❖ An in-mouth appliance used in the first course of orthodontic treatment after the injury

Temporomandibular Joint Dysfunction (TMJ)

Covered medical expenses include only charges for:

- ❖ Physical therapy
- ❖ Trigger point injections
- ❖ Mouth appliance/splint (limited to one)
- ❖ Surgery to alter the jaw, jaw joint or bite relationship by cutting procedure when appliance therapy alone cannot result in functional improvement

Excluded Services

Not included are charges:

- ❖ To remove, repair, replace, restore or reposition teeth lost or damaged in the course of biting or chewing
- ❖ To repair, replace, or restore fillings, crowns, dentures or bridgework
- ❖ For non-surgical periodontal treatment
- ❖ For dental cleaning, in-mouth scaling, planing or scraping
- ❖ For myofunctional therapy (This is muscle training therapy or training to correct or control harmful habits.) for root canal therapy
- ❖ For routine tooth removal (not needing cutting of bone)

Organ/Tissue Transplants

Pre-certification must be obtained at least seven working days before the scheduled date of any of the following or as soon as reasonably possible:

- ❖ The evaluation
- ❖ The donor search
- ❖ The organ procurement/tissue harvest
- ❖ The transplant procedure

Services and supplies for necessary organ or tissue transplants are payable under this Plan.

Donor Charges for Organ/Tissue Transplants

- ❖ In the case of an organ or tissue transplant, donor charges are considered covered expenses ONLY if the recipient is a covered person under this Plan. If the recipient is not a covered person, no benefits are payable for donor charges
- ❖ The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a covered service UNLESS the search is made in connection with a transplant procedure arranged by a Designated Transplant Facility

If a qualified procedure listed below is necessary and performed at a Designated Transplant Facility, the medical care and treatment and transportation and lodging provisions described below apply.

Qualified Procedures

- ❖ Heart transplants
- ❖ Lung transplants
- ❖ Heart/lung transplants

- ❖ Liver transplants
- ❖ Kidney transplants
- ❖ Pancreas transplants
- ❖ Kidney/pancreas transplants
- ❖ Bone marrow/stem cell transplants
- ❖ Other transplant procedures the Plan Administrator determines to be necessary provided the procedure is performed at a Designated Transplant Facility.

Medical Care and Treatment

The covered expenses for services provided in connection with the transplant procedure include:

- ❖ Pre-transplant evaluation for one of the procedures listed above
- ❖ Organ acquisition and procurement
- ❖ Hospital and physician fees
- ❖ Transplant procedures
- ❖ Follow-up care for a period up to one year after the transplant
- ❖ Search for bone marrow/stem cell from a donor who is not biologically related to the patient. If a separate charge is made for bone marrow/stem cell search, a maximum benefit of \$25,000 is payable for all charges made in connection with the search.

Transportation and Lodging

Pre-certification will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows:

- ❖ Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up
- ❖ Reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to \$50 for one person or up to \$100 for two people
- ❖ Travel and lodging expenses are only available if the transplant recipient resides more than 100 miles from the Designated Transplant Facility
- ❖ If the patient is a covered dependent minor child, the transportation expenses of two companions will be covered and lodging and meal expense will be reimbursed up to the \$100 per diem rate
- ❖ There is a combined overall lifetime maximum of \$10,000 per covered person for all transportation, lodging, and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan in connection with all transplant procedures

Physical Therapy

Services of a licensed physical therapist provided the following conditions are met:

- ❖ The therapy must be ordered and monitored by a physician
- ❖ The therapy must be medically necessary for the care and treatment of an illness or injury
- ❖ The therapy must be given in accordance with a written treatment plan approved by a physician. The therapist must submit progress reports at the intervals stated in the treatment plan

Therapy for developmental delay for a dependent child age 18 months to age 5 only is limited to 20 visits per calendar year. This limit does not apply to treatment of autism.

Wigs

Prosthetic wigs prescribed by a physician required as a result of an injury or illness up to a lifetime maximum of \$500 for each person. Among the covered conditions is hair loss due to chemotherapy and alopecia areata. This is subject to the Plan Administrator's determination that a proposed course of treatment is medically appropriate and not experimental and investigational. Wigs for male pattern baldness are excluded.

Physician Services

Medical Care and Treatment

- ❖ Hospital, office and home visits
- ❖ Emergency room services

Surgery - Services for surgical procedures

Reconstructive Surgery

1. Reconstructive surgery to improve the function of a body part when the malfunction is the direct result of one of the following:
 - ❖ Birth defect
 - ❖ Sickness
 - ❖ Surgery to treat a sickness or accidental injury
 - ❖ Accidental injury
2. Reconstructive breast surgery following a necessary mastectomy. Following a mastectomy, reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses and treatment of physical complications of all stages of mastectomy, including lymph edemas.
3. Reconstructive surgery to remove scar tissue on the neck, face, or head if the scar tissue is due to sickness or accidental injury.
4. Cosmetic procedures are excluded from coverage. Procedures that correct a congenital anomaly without improving or restoring physiologic function are considered cosmetic procedures. The fact that a covered person may suffer psychological consequences or socially avoidant behavior as a result of an injury, sickness or congenital anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure. Cosmetic surgery to correct the function of a part of the body as a:
 - ❖ Result of an accidental injury sustained while a person is covered under the Plan
 - ❖ Treatment of a condition that impairs the function of a body organ
 - ❖ Reconstructive surgery to repair damage resulting from a disfiguring disease that occurred while covered under the Plan

Assistant Surgeon Services

Covered expenses for assistant surgeon services are limited to 20% of the amount of covered expenses for the surgeon's charge for the surgery. An assistant surgeon must be a physician. Surgical assistant's services are not covered.

Multiple Surgical Procedures

Multiple surgical procedures means more than one surgical procedure performed during the same operative session. Covered expenses for multiple surgical procedures are limited as follows: Covered expenses for secondary and subsequent procedures are limited to 50% of the covered expenses that would otherwise be considered for the secondary procedure had it been performed during a separate operative session.

Other Physician Service Limitations

Services provided by a podiatrist may be limited. See "Expenses that are Not Covered under Choice POS II / Choice Plus Plans" for details.

Chiropractor

The covered expenses for chiropractic services are limited to those services medically necessary and are subject to an annual maximum of \$2,500 per covered individual per calendar year. Maintenance therapy is not covered.

Pregnancy Benefits

Benefits are payable for covered services and supplies for pregnancy given to the covered person while covered under this Plan. Benefits for pregnancy are paid in the same way as benefits are paid for sickness. The child must be added to the plan within 31 days of birth or newborn expenses are ineligible.

Benefits are payable for at least:

- ❖ 48 hours of inpatient care for the mother and newborn child following a normal vaginal delivery
- ❖ 96 hours of inpatient care for the mother and newborn child following a cesarean section

The hospital or other provider is not required to get authorization from the Plan Administrator for the time periods stated above. Authorizations are required for longer lengths of stay. Federal law prohibits the mother's or newborn's attending physician, after consulting with the mother, from discharging the mother or her newborn child earlier than 48 hours (or 96 hours, as applicable).

The office visit copay does not apply to prenatal and postnatal office visits (after the initial diagnosis) by the Network obstetrician/gynecologist, who is primarily responsible for the patient's maternity care.

Additional covered services and supplies specific to pregnancy are listed below.

Birth Center Services

- ❖ Room and board
- ❖ Other services and supplies
- ❖ Anesthetics

Nurse-Midwife's Services

The services of a licensed or certified nurse-midwife

Routine Well Baby Care

The following services and supplies given during a newborn child's initial hospital confinement:

- ❖ Hospital services for nursery care
- ❖ Other services and supplies given by the hospital
- ❖ Services of a surgeon for circumcision
- ❖ Physician services

Exclusions and limitations that apply to these benefits are described in "Expenses that are Not Covered in the Choice POS II / Choice Plus" that follows.

Preventive Health Care Benefits

Benefits are payable for covered services and supplies for preventive health care benefits given to a covered person by a network physician while the person is covered under this Plan. Preventive services rendered by a non-network provider are not eligible. (Note: If you are in the passive PPO your benefits are different. Refer to the Medical Benefits-at-a-Glance chart for details.)

Covered services and supplies include **only** those specifically listed below:

- ❖ Well-child immunizations for covered dependents through age 17. Covered immunizations include the following: diphtheria, pertussis, tetanus, hemophilus, influenza, oral polio, hepatitis A, hepatitis B, measles, mumps, rubella, chicken pox, meningitis and one tuberculosis skin test. Deductible is waived;

the plan pays 80% benefit (if done in conjunction with well baby office visit, you pay office visit co-pay only)

- ❖ Well-baby office visits for covered dependents through age 5. You pay the office visit copay only
- ❖ Routine physical exams subject to office visit copay:

Dependents age 6 through age 17	Limit one exam every 24 months
Adult physical exams age 18 through age 64	Limit one exam every 24 months
Age 65 and over	Limit one exam every 12 months

Covered services include age and gender appropriate clinical screenings, immunizations and lab/x-ray tests in accordance with guidelines followed by Aetna and UHC network providers. Preventive screenings prescribed by physician during a covered physical but performed at an offsite facility are subject to co-insurance/deductible waived

- ❖ **Mammograms:** (American Cancer Society Guidelines) One baseline exam is covered for women ages 35-39. Thereafter, one exam every year is covered for women 40 and over. Deductible is waived; the plan pays 80% benefit.
- ❖ **Colon Cancer Screenings:** (American Cancer Society Guidelines) One yearly fecal occult blood screening and one colonoscopy every ten years for associates/dependents age 50 and over. Deductible is waived; the plan pays 80% benefit.
- ❖ **Prostate Cancer Screenings:** (American Cancer Society Guidelines) One yearly screening is covered for associates/dependents age 50 and over. Deductible is waived; the plan pays 80% benefit.
- ❖ **Routine Pap Smears:** (American Cancer Society Guidelines) one yearly screening is covered for associates/dependents as recommended by their physician. Deductible is waived; the Plan pays 80% benefit.
- ❖ **HPV Screenings:** (FDA Guidelines) one yearly screening is covered for women age 30 and over. HPV vaccine for girls and women ages 9 through 26 is covered. Deductible is waived; the Plan pays 80% benefit.
- ❖ **Inpatient Newborn Exam:** Hospital exam for discharge of newborn is covered. Deductible is waived; the Plan pays 80% benefit.
- ❖ **Flu Shots:** Deductible is waived; the plan pays 80% benefit.
- ❖ **Herpes Zoster Vaccine for Shingles age 60 and older:** Deductible is waived; the Plan pays 80% benefit. If the Zostavax vaccine is purchased by the member, the vaccine is subject to benefits under the ADP Prescription Drug Plan and the physician services to administer the vaccine are subject to the medical benefit.

Note: Preventive cancer screenings done at covered routine physical subject to office visit copay. Exclusions and limitations that apply to these benefits are described in "Expenses that are Not Covered in the Choice POS II / Choice Plus" section that follows.

Private Duty Nursing Care

Private Duty Nursing Care is pre-approved services of a nurse who is either a registered nurse (RN) or licensed practical nurse (LPN), and those of a licensed physical therapist. Private duty nursing is care given on an outpatient basis by a licensed nurse (RN, LPN, or LVN). The maximum number of shifts per year is 70.

Speech Therapy

Speech therapy performed by a licensed speech pathologist for loss or impairment due to injury or illness. The Plan pays for charges for the diagnosis or non-surgical treatment by a physician for loss or impairment of speech, but only if the charge is made for:

- ❖ Diagnostic services rendered to find out if and to what extent the person's ability to speak is lost or impaired
- ❖ Rehabilitative services rendered that are expected to restore or improve a person's ability to speak

Not covered are charges for:

- ❖ Diagnostic or rehabilitative services rendered before the person becomes eligible for coverage or after termination of coverage
- ❖ Special education for a person whose ability to speak is lost or impaired. This includes lessons in sign language

The therapy must be expected to result in significant, objective, measurable physician improvement in the covered person's condition within two months of the start of the treatment. This provision does not include charges for educational therapy or services that are developmental in nature, except as otherwise indicated. Therapy for developmental delay for a dependent child age 18 months to age 5 only is limited to 20 visits per calendar year. This limit does not apply to treatment of autism.

Spinal Manipulations

The covered expenses for chiropractic services are limited to those services medically necessary and are subject to an annual maximum of \$2,500 per covered individual per calendar year. Maintenance therapy is not covered.

Lifetime Maximum Benefit Amount

A \$3,000,000 lifetime benefit maximum per covered individual applies under the Choice POS II / Choice Plus Medical and Prescription Drug Plans. This provision was effective January 1, 2002 and applies to claims processed on and after January 1, 2002.

Any lifetime maximum applicable under an HMO Plan offered by ADP is separate from this lifetime maximum.

Aetna Vision One (applies to associates enrolled in Aetna Choice POS II)

The Vision One Discount Program is available to Aetna members at no additional cost. This program may help you and your family save on many eye care products, including eyeglasses and contact lenses, non-prescription sunglasses, contact lens solution and accessories. The Vision One Program is available at many optical centers nationwide such as Sears, JC Penney, Montgomery Ward, most Pearle Vision Centers and others. Call 800-793-8616 weekdays from 9:00 a.m. to 9:00 p.m. ET and Saturdays from 9:00 a.m. to 5:00 p.m. ET for more information.

Expenses that are Not Covered under Choice POS II / Choice Plus Plans

There are services that are not covered under the Comprehensive Health Care Plan as is normal for most group arrangements. This Plan does not cover any expenses incurred for services, supplies, medical care or treatment relating to, arising out of, or given in connection with the following:

1. Services or supplies received before an associate or his or her dependent becomes covered under this Plan.
2. Smoking Cessation expenses are not covered. See Prescription Drug Benefit section for the covered expense.

3. Expenses for birth control pills and devices including IUD (unless as specified under Covered Services section of medical plan), norplant and diaphragm. Excluded are cost of insertion, removal and device itself. Birth Control pills are covered under the managed prescription drug program administered by Medco. See the Prescription Drug Benefit section for covered expenses under that Plan.

4. Fees charged for completion of claim forms or missed appointments.

5. Cosmetic surgery or treatment, unless to correct the result of an accidental injury sustained while covered under the Plan; to repair a birth defect; or for reconstructive surgery to repair damage resulting from a disfiguring disease that occurred while covered under the Plan. See "Physicians Services" in the "Covered Services in Choice POS II / Choice Plus Plan" section for limited coverage of reconstructive surgery.

6. Custodial Care: Services and supplies are considered custodial and not covered when they:

- ❖ Are furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide therapeutic treatment. This includes room & board and other institutional care
- ❖ Can safely and adequately be provided by persons without the technical skills of a covered health care provider (physicians, RNs)

Care meeting the above criteria is not covered regardless of:

- a) Who recommends, provides or directs the care
- b) Where the care is provided
- c) whether or not the patient or another caregiver can be or is being trained to care for him or herself

7. Ecological or environmental medicine, diagnosis and/or treatment. Care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease or injury.

8. Education, training and bed and board while confined in an institution for training, a place of rest, a place for the aged or a nursing home.

9. Eye glasses, contact lenses, eye refractions, and eye surgery mainly to correct refractive errors. Hearing aids in excess of what is included under "Hearing Care" in the "Covered Services in Choice POS II / Choice Plus Plan" section above.

10. Herbal medicine, holistic or homeopathic care, including drugs.

11. Services, supplies, medical care or treatment given by one of the following members of the Associate's immediate family:

- ❖ The associate's spouse
- ❖ The child, brother, sister, parent, or grandparent of either the associate or the associate's spouse

12. Charges for procedures such as invitro fertilization, artificial insemination, embryo transfer, gamete intrafallopian transfer, zygote intrafallopian transfer and tubal ovum transfer in excess of what is included under "Infertility Treatment" in the "Covered Services in the Choice POS II / Choice Plus Plan" section above.

13. For experimental procedures or investigational services or supplies. A charge for a service or supply is not covered to the extent that it is experimental or investigational. Charges in connection with such a service or supply are also not covered. A service or supply will be considered "experimental or investigational" if:

- (a) The drug, medical service or supply is under study or in a clinical trial to evaluate its toxicity, safety, or efficacy for a particular diagnosis or set of indications. This includes: